

Exhibit 57

United States of America ex rel. Ven-a-Care of the Florida Keys, Inc v. Abbott Laboratories, Inc.; Dey, Inc., et al.; Boehringer Ingelheim Corp., et al.;
Civil Action No. 01-12257-PBS

Exhibit to the September 22, 2009, Declaration of George B. Henderson, II
In Support of Plaintiff's Response to Defendants' Combined Local Rule 56.1
Statement of Additional Material Facts Pertinent to the United States' Motions
for Partial Summary Judgment Against Defendants

OK Health Care Authority (Nancy Nesser)

December 12, 2008

Oklahoma City, OK

Page 1

THE UNITED STATES DISTRICT COURT
FOR THE DISTRICT OF MASSACHUSETTS

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In Re: PHARMACEUTICAL INDUSTRY) MDL No. 1456
AVERAGE WHOLESALE PRICE LITIGATION) Master File No.
-----) 01-CV-12257-PBS

THIS DOCUMENT RELATES TO:)
United States of America ex rel.) Hon. Patti B.
Ven-A-Care of the Florida Keys,) Saris
Inc., et al., v. Dey, Inc., et al.,)
Civil Action No. 05-11084-PBS;)
and United States of America ex) DEPOSITION OF
rel. Ven-A-Care of the Florida) THE OKLAHOMA
Keys, Inc., et al., v. Boehringer) HEALTH CARE
Ingelheim Corp., et al., Civil) AUTHORITY
Action No. 07-10248-PBS;) by NANCY
and United States ex rel. Ven-A-Care) NESSER
of the Florida Keys v. Abbott)
Laboratories, Inc., Civil Action) DECEMBER 12,
Nos. 06-CV-11337 and 07-CV-11618) 2008
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Page 2

1 VIDEOTAPE DEPOSITION OF THE OKLAHOMA
2 HEALTH CARE AUTHORITY by NANCY NESSER
3 TAKEN ON BEHALF OF THE DEFENDANTS
4 ON DECEMBER 12, 2008 AT 8:58 AM
5 IN OKLAHOMA CITY, OKLAHOMA
6
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8 VIDEOTAPED BY: Gabriel Pack

9 REPORTED BY: Jody Graham, CSR, RPR, RMR, CRR
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Page 54

1 just thinking about acquisition.

2 Q. Okay. When did you first become aware
3 of the difference between AWP and actual
4 acquisition costs for generic drugs?

5 A. That probably would have been later
6 than that. I mean, not all the way to '99, but
7 maybe '95, '96, somewhere in there.

8 Q. And in '95, '96 what was your
9 understanding of the difference between AWP and
10 actual acquisition costs for generic drugs?

11 A. That sometimes there was a wide
12 difference. Not always.

13 Q. Can you describe what you mean by "wide
14 difference"?

15 A. Just that it was -- it was variable.
16 It wasn't a standard. It wasn't, like, with the
17 brand name where you could -- you can see it's
18 consistent. If you pulled two manufacturers
19 brand-name products off the shelf, the markup is
20 going to be about the same. If you pulled two --
21 even of the same generic drug, the -- there's no
22 consistency between the AWP and the acquisition.

Oklahoma City, OK

Page 55

1 Q. So is it your understanding that there
2 was no particular formula or specified markup
3 between AWP and actual acquisition costs for
4 generic drugs starting in, you know, around 1995?

5 A. That would -- that would be a fair
6 statement, yes.

7 Q. Okay. You mentioned earlier that -- at
8 least with reference to the brand drugs, you
9 might, in purchasing drugs, consider the gap
10 between the AWP and the actual acquisition cost.
11 Did you choose who to buy your prescription drugs
12 from based on that spread between AWP and actual
13 acquisition costs?

14 A. Not typically. You know, there were a
15 few products where -- for example, I'm not going
16 to be able to -- Prinivil and Zestril were both
17 Lisinopril made by two different companies. But
18 they typically were priced almost to the penny
19 the same.

20 So when there were brand drugs where
21 you had two manufacturers, they seemed like they
22 would just price them pretty close. So there's

Oklahoma City, OK

Page 56

1 no benefit to getting one over the other.

2 Q. While you were working at any of the
3 pharmacies prior to working for Oklahoma
4 Medicaid, were you aware of anyone marketing the
5 spread?

6 A. I think I -- I remember being sort of
7 told, not exactly, but -- that was pointed out to
8 me. Not by a sales person, but by my boss.

9 Q. Okay. And what was pointed out to you
10 by your boss, exactly?

11 A. Just that -- just that -- that certain
12 -- certain generics had this lower price and that
13 we've got paid -- not necessarily based on AWP,
14 but we would get paid based on a maximum
15 allowable cost. And so you -- you wanted to find
16 the least expensive one because payors were
17 starting to put in maximum allowable cost
18 programs. And so you wanted to make sure you
19 were getting the best deal.

20 Q. Was it ever discussed, not just in
21 relation to maximum allowable costs, but in
22 relation to the difference between the price at

Oklahoma City, OK

Page 57

1 which you could acquire drugs and the AWP-based
2 reimbursement?

3 A. I don't remember that specifically.

4 Q. Okay. I would like to start with a
5 picture of how the Medicaid program works in
6 Oklahoma.

7 A. Okay.

8 Q. And in the federal government.
9 Medicaid in generally is partnership between the
10 federal government and the state governments;
11 correct?

12 A. Correct.

13 Q. Are you familiar with the term federal
14 matching assistance percentage?

15 A. Yes.

16 Q. What is federal matching assistance
17 percentage?

18 A. That is the amount that the federal
19 government contributes to a state's Medicaid
20 program.

21 Q. Essentially the federal government pays
22 a part of Oklahoma's expenditures under its

Oklahoma City, OK

Page 63

1 Q. When you mean "the rate is better than
2 any other payor in the state," do you mean that
3 other payors in the state reimburse providers at
4 a lower amount for the same prescription drugs as
5 Oklahoma Medicaid does?

6 A. Yes.

7 Q. Is that one way that Oklahoma Medicaid
8 encourages providers to participate in its
9 program?

10 A. Yes.

11 Q. What is the approximate number of
12 pharmacies in Oklahoma?

13 A. I believe it's -- just for retail
14 pharmacies I'm going to guess that it's around
15 1,100, something like that.

16 Q. Do you know how many of these
17 pharmacies participate in the Oklahoma Medicaid
18 program?

19 A. Virtually all of them are contracted.
20 There are about 900 that actively file claims.
21 Some of them may be in areas where there's not a
22 -- a heavy Medicaid population. So while they're

Oklahoma City, OK

Page 64

1 contracted, they just may not have a claim in a
2 given year.

3 Q. Has the percentage of pharmacies in
4 Oklahoma Medicaid that participate in its
5 Medicaid program changed over time?

6 A. Not that I'm aware of.

7 Q. Are there any factors in Oklahoma that
8 make access to care a particular concern?

9 A. There are some areas which are fairly
10 rural, and there may be only one pharmacy in some
11 of the more sparsely populated counties. I don't
12 think that there are any counties that don't have
13 a pharmacy at all at this point; but there are
14 some, especially in the panhandle and in the far
15 southwest part of the state, where it may be, you
16 know, a 30-mile drive to a pharmacy or a
17 physician.

18 Q. What do you consider Oklahoma's goals
19 with respect to its Medicaid program?

20 A. Can you be a little more specific than
21 that? I mean, that's a pretty broad question.

22 Q. Does Oklahoma Medicaid have overall

Oklahoma City, OK

Page 89

1 Medicaid providers for the 2002 change to
2 reimbursement formula?

3 A. No. I don't recall even receiving
4 letters or complaints.

5 Q. Would you have been the one to receive
6 any letters or complaints?

7 A. They would have eventually made their
8 way to me, yes.

9 Q. Would all complaints have made their
10 way to you?

11 A. For this rate change, yes.

12 Q. Drug manufacturers weren't involved in
13 making the decision to change the reimbursement
14 formula in 2002, were they?

15 A. No.

16 Q. Were Medicaid providers consulted prior
17 to making changes in general to Oklahoma
18 Medicaid's reimbursement methodology for
19 prescription drugs?

20 A. "In general," you mean?

21 Q. Was it Oklahoma Medicaid's practice to
22 consult providers prior to making changes to its

Oklahoma City, OK

Page 90

1 reimbursement formula?

2 A. Not that I know of.

3 Q. You mentioned that the Oklahoma
4 Pharmacists Association was involved to some
5 extent in the process in 2002 to making changes
6 to the reimbursement formula. Could you describe
7 their involvement in that process.

8 A. As I recall, we, you know, certainly
9 had a few courtesy meetings with them to address
10 any concerns that they might have. And I don't
11 specifically recall, but they could have made
12 public comment at the rates and standards
13 hearing.

14 Q. Why did Oklahoma Medicaid consult with
15 the Oklahoma Pharmacists Association prior to
16 making changes to the reimbursement formula?

17 A. Mainly just as a courtesy because
18 they're the association that would represent the
19 pharmacy providers.

20 Q. If you didn't receive complaints from
21 providers either through that association or
22 otherwise, would your understanding have been

Oklahoma City, OK

Page 91

1 that it was because the reimbursement formula was
2 sufficient to encourage their participation in
3 Medicaid?

4 A. That would be my understanding, yes.

5 Q. Drug manufacturers have not had any
6 authority to set or change the reimbursement
7 methodology used by Oklahoma Medicaid; correct?

8 A. That's correct.

9 Q. As we discussed, Oklahoma is given
10 discretion by CMS to set a specific reimbursement
11 methodology to pay providers for prescription
12 drugs that are dispensed to Medicaid
13 beneficiaries; correct?

14 A. Uh-huh.

15 Q. You're aware that different states have
16 chosen different methodologies?

17 A. Yes.

18 Q. One of the reasons that different
19 states had different methodologies was that
20 states, such as Oklahoma, tailor their
21 reimbursement methodology to fit local needs;
22 correct?

Oklahoma City, OK

Page 222

1 Q. Does Oklahoma Medicaid use a point-of-
2 sale system?

3 A. You mean to pay the claims?

4 Q. Uh-huh.

5 A. Yes.

6 Q. AWP is not defined in Oklahoma
7 regulations, is it?

8 A. I don't think it's specifically
9 defined. It's referred to.

10 Q. AWP is not defined in Oklahoma
11 statutes, is it?

12 A. Oh, not in Oklahoma statutes, I don't
13 believe so, no.

14 Q. Oklahoma could have defined AWP as
15 actual acquisition costs, if it had wanted to;
16 correct?

17 A. I suppose so.

18 Q. When Oklahoma makes decisions regarding
19 reimbursement methodology for prescription drugs,
20 it draws upon various sources of information that
21 are available to it; correct?

22 A. Correct.

Oklahoma City, OK

Page 223

1 Q. The OIG reports we discussed are one of
2 the sources of information?

3 A. Yes.

4 Q. And surveys or reports conducted at the
5 direction of Oklahoma Medicaid would be other
6 sources of information that were considered?

7 A. Yes.

8 Q. Myers & Stauffer's report prepared at
9 Oklahoma Medicaid's discretion would be another
10 source of information it could consider?

11 A. You mean, if we hired them or -- you
12 mean, in the past?

13 Q. In the past when Oklahoma Medicaid did
14 hire Myers & Stauffer.

15 A. Sure.

16 Q. And when Oklahoma Medicaid makes
17 decision regarding its prescription drug payment
18 rates and dispensing fees, it also draws upon the
19 expertise of the people working for the state;
20 correct?

21 A. Correct.

22 Q. Ultimately the payment rate that is

Oklahoma City, OK

Page 224

1 adopted is a decision that the state makes;
2 correct?

3 A. Correct.

4 Q. For instance, Oklahoma Medicaid chooses
5 for itself whether to reimburse providers based
6 on AWP minus a discount; correct?

7 A. Correct.

8 Q. Oklahoma Medicaid is not required to
9 use AWP as a bench mark in its reimbursement
10 formula?

11 A. That's correct.

12 Q. Oklahoma Medicaid could choose to
13 reimburse providers based on WAC, if it wanted
14 to; correct?

15 A. Correct.

16 Q. Oklahoma Medicaid could choose to
17 reimburse providers based on an actual
18 acquisition cost, if it wanted to; correct?

19 A. Correct.

20 Q. There are several constituencies
21 outside of the Medicaid agency that have strong
22 interests in what decisions are made within the

Oklahoma City, OK

Page 225

1 agency about prescription drugs; correct?

2 A. Correct.

3 Q. In the case of Oklahoma Medicaid, some
4 of those constituency groups are providers;
5 correct?

6 A. Correct.

7 Q. And that includes pharmacists; correct?

8 A. Correct.

9 Q. Does Oklahoma consult with any pharmacy
10 associations in general when setting policies or
11 rates for reimbursement of prescription drugs?

12 A. Yes.

13 Q. Which pharmacy associations?

14 A. We consult with the Oklahoma
15 Pharmacists Association, and there's another
16 group called Pharmacy Providers of Oklahoma.

17 Q. And how does Oklahoma consult with the
18 Oklahoma Pharmacists Association and Pharmacy
19 Providers of Oklahoma?

20 A. We usually have a meeting with them, a
21 face-to-face.

22 Q. And what's discussed at those meetings

Oklahoma City, OK

Page 226

1 about reimbursing for prescription drugs?

2 A. Just whatever the issue is. I mean,
3 they're -- they're pretty focused meetings.

4 Q. How often do these meetings or
5 communications occur?

6 A. They've probably occurred maybe once a
7 year since I've been there. Maybe twice if
8 there's either a -- some legislative proposal or,
9 you know, from any of them or from someone else.
10 We might meet with them for that.

11 But yet they're not -- they're not,
12 like, monthly or anything regularly scheduled.

13 Q. You wouldn't consider that there's
14 anything improper about pharmacies expressing
15 their opinions about regulations that affect
16 them, would you?

17 A. No.

18 Q. Providers had an interest in keeping
19 reimbursement high because they're in the
20 business to make some sort of profit; correct?

21 MR. MAO: Objection, form.

22 THE WITNESS: Correct.